COUNTY OF SAN BERNARDINO STANDARD PRACTICE	NO 11-1.14	ISSUE 4/98 PAGE 1 OF 2
	BY Access Unit	EFFECTIVE 4/98
DEPARTMENT BEHAVIORAL HEALTH	APPROVED James McReynolds	
SUBJECT OUTPATIENT CLINIC/FFS PATIENTS' COMPLAINT PROCEDURE	James McReynolds, Director	

I. PURPOSE

To describe the Consumer Complaint and Grievance procedures for Outpatient Clinics and FFS Specialty Mental Health Services.

II. POLICY

Individuals who are receiving mental health services through the Department of Behavioral Health or through one of the contract agencies and/or Fee for Service providers are entitled to complain about services received, to their care provider, the DBH Access Unit, or the Patients' Rights Office, file a Grievance, and request a State Fair Hearing.

III. PROCEDURE

A. For the purpose of this process, a complaint is verbal and a grievance is written.

B. Staff should make every effort to resolve complaints at the proper level. Resolution may be reached through disclosures between the Consumer and Therapist/Case Management, Program Manager or the Access Unit. Additionally the Patients' Rights office is an available resource.

C. If complaints can not be resolved at the Provider level, a Grievance Form (Attachment 1) may be completed by the Consumer and sent to the Access Unit which will be forwarded to the Quality Improvement Committee for resolution.

D. The following are Grievance Procedures when the Consumer is dissatisfied following the receipt of a Notice of Action Letter which denies, reduces or terminates service.

1. A consumer may complete a request for a Second Opinion Form (attachment #2) which is to be forwarded to the Access Unit.

2. A written decision is to be made by the Access Unit in seven calendar days from the date of receipt of the form, and mailed to the consumer. Information on the process for requesting further review (#3 below) is to be included in this mailing.

3. If the consumer is still unsatisfied with the resolution, he/she may request a further review by a department committee where the members could include but not be limited to Deputy Directors, Quality Improvement Committee Members, and Patients Rights' Staff.

4. In addition, clients who have received a Notice of Action Letter indicating services have been denied, reduced or terminated may request a State Fair Hearing. The client has 90 days in which to request the hearing. The Consumer may also be eligible to continue receiving service pending the outcome of the hearing, if the request is made within 10 days of receipt of the NOA.

5. The "Fair Hearing Appeal Tracking Log" will be maintained by the Access Unit to monitor the progress and resolution if each request for a Fair Hearing. This log will also include relevant information about the consumers' ethnic background and/or linguistic needs (Attachment #3).

6. The Access Unit is responsible for coordination with the State Department of Social Service, State Department of Mental Health, providers and consumers regarding The Fair Hearing process. The Access Unit will also oversee compliance with the decision of the hearing.

7. Hearings are requested through by calling or writing to:
   Public Inquiry and Response
   744 - P St. M.S. 16-23
   Sacramento, CA 95814
   1-800-952-5253
   1-800-952-8349 (TDD)

8. The Patients' Rights Office may be involved at any level of the Complaint/Grievance Process.

BF:ks
a \ptrights spm

No.:_____

COMPLAINT/GRIEVANCE FORM
S.B. COUNTY MENTAL HEALTH PLAN

CONSUMER TO BE COMPLETED BY

DATE:	**TIME:**	**SOC. SECURITY #:**
PATIENT'S NAME:	**DOB:**	**PHONE #:**
MALE: _____ **FEMALE:** _____	**ETHNICITY:**_____	**LANGUAGE:**_____
ADDRESS:		
COMPLAINT:		
DESIRED RESOLUTION:		

ACTION TAKEN/OUTCOME OF COMPLAINT (Check appropriate option)

STAFF TO BE COMPLETED BY

- ☐ **(1) Resolution reached (specify action)**
- ☐ **(2) Level 1 (Supervisor) Grievance initiated (date)**
- ☐ **(3) Level 2 (Program Manager) Grievance initiated (date)**
- ☐ **(3) Complaint referred to Patients' Rights Office (date)**
- ☐ **(4) Reported to DBH Quality Management Committee (date)**
- ☐ **(5) Beneficiary sent written notification of disposition (date)**

OTHER:

Access Staff Signature		**Date**

SAN BERNARDINO COUNTY

DEPARTMENT OF BEHAVIORAL HEALTH/MENTAL HEALTH PLAN

REQUEST FOR SECOND OPINION

As a Medi-Cal beneficiary, you may use this form to request a second opinion about a decision or action of the Mental Health Plan with which you disagree.

Please fill out this form as best you can in your own words. You can get help with the form from your therapist or physician or from the Patients' Rights Office (909-387-7055). Please turn in the completed form to your therapist or physician, who will mail or fax it to the Access Clinic, 700 E. Gilbert St.; San Bernardino CA 92415-0920; fax 909-386-0775. A second opinion will be rendered within seven calendar days of receipt (excluding holidays) by the supervisor of the Access Clinic.

Why did you originally come to us for help?

What kind of help or specific services do you think you need from us?

Why are you requesting a second opinion?

How would you like to have the problem resolved, or what would you like done differently?

Did you receive a Notice of Action Letter regarding this matter?
yes no

Client (Beneficiary) Signature_____ **Date**_____

Received by_____ **Date**_____

Client Name_____ **DOB**_____ **Chart No.**_____

D20/secopin 2-98

FAIR HEARING APPEAL TRACKING LOG

Client Name	Type of Document	Nature of the Problem	Date Received	Hearing Date	Position Paper Date (Due 2 Days Before Hearing)	Date Position Paper Completed	Pull NOA (Before Hearing Date)	Case #	Hearing Decision	WITHDRAWAL INFORMATION				Date Received	Date to Carol (30 Days to Comply)	Compliance Plan	Date Compliance Plan to DMH
										Verbal Agreement Date	Date Letter to Client	Date Letter Returned From Client	Conditional Total Agreement				

No. 11-1.14, Attachment 3, Page 1 of 1